

THE DIVISION OF HEALTH OF MISSOURI

FILED MAR 5 1949

STANDARD CERTIFICATE OF DEATH

State File No. 6590

318

PRIMARY REG. DIST. NO.

1003

Registrar's No. 1841

BIRTH NO.

REG. DIST. NO.

PRIMARY REG. DIST. NO.

Registrar's No.

1. PLACE OF DEATH

a. COUNTY

b. CITY (If outside corporate limits, write RURAL and give township)
OR
TOWN St. Louisc. LENGTH OF
STAY (In this place)d. FULL NAME OF
HOSPITAL OR
INSTITUTION Homer G Phillips Hospital

2. USUAL RESIDENCE (Where deceased lived. Indicate residence before admission.)

a. STATE

Missouri

b. COUNTY

St. Louis 76

c. CITY (If outside corporate limits, write RURAL and give township)
OR
TOWN St. Louis Clayton, Mo.d. STREET
ADDRESS(If rural, give location)
7454 Parkside A

3. NAME OF DECEASED

(Type or Print)

a. (First)

Andrew

b. (Middle)

J

c. (Last)

Reid

4. DATE

(Month)

(Day)

(Year)

OF
DEATH

Feb. 3

1949

5. SEX

Male

6. COLOR OR RACE

Colored

7. MARRIED, NEVER MARRIED,
WIDOWED, DIVORCED (Specify)

Sep.

8. DATE OF BIRTH

Mar. 10, 1864

9. AGE (In years
last birthday)

84

10

3

Hours

Mins.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life even if retired)

nil

10b. KIND OF BUSINESS OR IN-
DUSTRY

11. BIRTHPLACE (State or foreign country)

V

12. CITIZEN OF WHAT
COUNTRY?

13a. FATHER'S NAME

Allen Reid

13b. MOTHER'S MAIDEN NAME

Emma Anderson

14. NAME OF HUSBAND OR WIFE

Wife - not known

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes, give war or dates of service)16. SOCIAL SECURITY
NO.

Unknown

17. INFORMANT'S SIGNATURE OR NAME

Elizabeth Rhodes, 2601 N Whittier St

18. CAUSE OF DEATH

Enter only one cause per
line for (a), (b), and (c)*This does not mean
the mode of dying, such
as heart failure, ashenia,
etc. It means the dis-
ease, injury, or complica-
tion which caused death.I. DISEASE OR CONDITION
DIRECTLY LEADING TO DEATH*

(a) Pulmonary Tuberculosis

ANTECEDENT CAUSES

Morbidity conditions, if any, giving
rise to the above cause (a) stating
the underlying cause last.

DUE TO (b)

Not known

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not
related to the disease or condition causing death.

None

INTERVAL BETWEEN
ONSET AND DEATH

Undet.

19a. DATE OF OPERA-
TION

None

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐NO ☒21a. ACCIDENT
SUICIDE
HOMICIDE

(Specify)

21b. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP)

(COUNTY)

(STATE)

21d. TIME
OF
INJURY

(Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2-2, 1949, to 2-3, 1949, that I last saw the deceased
alive on 2-3, 1949, and that death occurred at 11:45 pm., from the causes and on the date stated above.

23a. SIGNATURE

Oscar L. Daniels

(Degree or title)

M. D.

23b. ADDRESS

2601 N Whittier St

23c. DATE SIGNED

2-7-49

24a. BURIAL, CREMA-
TION, REMOVAL (Specify)

24b. DATE

FEB 28 1949

24c. NAME OF CEMETERY OR CREMATORY

Anatomical Board

24d. LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL
REG.

FEB 28 1949

REGISTRAR'S SIGNATURE

J. B. Sauter

25. FUNERAL DIRECTOR'S SIGNATURE

Rowland Mortuary Service

4104 Manchester Ave.

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

_____, Student Embalmer No. _____

working under my personal supervision.

Signed _____

Signed
Student Embalmer

Licensed Embalmer No. _____

P. O. Address _____

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.